| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295045 | A. BUILDING _____ B. WING _____ | C 07/09/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TORREY PINES CARE CENTER | 1701 S. TORREY PINES DRIVE LAS VEGAS, NV 89146 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>This Statement of Deficiencies was generated as a result of a complaint survey conducted at your facility on 07/09/08.<br><br>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.<br><br>Complaint # NV00018676 was substantiated with deficiencies.<br><br>The following regulatory deficiencies were identified. | F 000 | | |
| F 157 SS=D | 483.10(b)(11) NOTIFICATION OF CHANGES<br><br>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative | F 157 | | 8/27/08 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295045 | A. BUILDING _____ B. WING _____ | C 07/09/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TORREY PINES CARE CENTER | 1701 S. TORREY PINES DRIVE LAS VEGAS, NV 89146 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 157 | Continued From page 1<br>or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to immediately notify an interested family member about an injury requiring physician intervention for 1 of 1 resident.<br><br>Findings include:<br><br>Resident #1 was admitted on 6/10/2008 with the following medical diagnoses: altered mental status, improved, history of old cardiovascular accident (CVA), urinary track infections (UTI) being treated, hematuria resolved, severe debility, malnutrition status post gastrostomy tube placement, history of gastritis noted on esophagogastroduodenoscopy (EGD), respiratory insufficiency, asthma, chronic anemia, history of degenerative joint disease, Alzheimer's dementia, and cholethiasis noted on CT scan.<br><br>On 7/01/2008, an x-ray report of the resident's left shoulder stated the following impression: "minimal impaction fracture of the humeral head is suspected on the external rotation view. Correlation to patient's injury mechanism is recommended." | F 157 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295045 | A. BUILDING _____ B. WING _____ | C 07/09/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TORREY PINES CARE CENTER | 1701 S. TORREY PINES DRIVE LAS VEGAS, NV 89146 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 157 | Continued From page 2<br><br>Interview<br><br>At 4:25 PM on 07/09/2008, the nursing supervisor reported the resident's son was called on 07/08/2008, and told of the resident's shoulder injury for "the first time, I'm so sorry." The nursing supervisor could not explain the late notification. The nurse supervisor had indicated that she had documented the family notification and placed in the resident's medical record.<br><br>Record Review<br><br>At 4:25 PM on 7/09/2008, no documentation notifying the resident's family of her injury was available in the resident's medical record. The nursing supervisor related, "I must have put it in the wrong chart." | F 157 | | |
| F 309 SS=D | 483.25 QUALITY OF CARE<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to provide the care necessary to maintain the highest practicable level of physical, mental, and psychosocial well-being in accordance with the plan of care, for 1 of 1 residents.<br><br>Findings include: | F 309 | | 8/27/08 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295045 | A. BUILDING _____ B. WING _____ | C 07/09/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TORREY PINES CARE CENTER | 1701 S. TORREY PINES DRIVE LAS VEGAS, NV 89146 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 309 | Continued From page 3 | F 309 | | |

Resident #1

Resident #1 was admitted on 6/10/2008 with the following medical diagnoses: altered mental status, improved, history of old cardiovascular (CVA), urinary track infection (UTI) being treated, hematuria resolved, severe debility, malnutrition status post gastrostomy tube placement, history of gastritis noted on esophagogastroduodenoscopy (EGD), respiratory insufficiency, asthma, chronic anemia, history of degenerative joint disease, Alzheimer's dementia, and cholethiasis noted on CT scan.

1. Interview

The LPN (licensed practical nurse) reported that she gave the pain medication scheduled for 7/09/08 at 8:00 PM early at 4:45 PM, because the resident was "shouting."

Record Review

On 7/09/08 at 4:00 PM, the "Physician's Telephone Orders" listed the following orders dated 6/30/08:

- "OxyContin 10 mg (milligrams) po (per mouth) q (every) 12 hours,"
- "D/C (discontinue) Percocet PRN (as needed) q 4 hours," and
- "Please give pt (patient) Percocet q 6 hours for pain."

On 7/09/08 at 4:55 PM, the resident's MAR (medication administration record) was reviewed. The MAR listed "OxyContin 10 mg 1 tab (tablet) per GT (gastrostomy tube) BID (twice a day) to be

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295045 | A. BUILDING _____ B. WING _____ | C 07/09/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TORREY PINES CARE CENTER | 1701 S. TORREY PINES DRIVE LAS VEGAS, NV 89146 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 309 | Continued From page 4 | F 309 | | |

given at 0800 and 2000 (8:00 PM.)" The 2000 dose was initialed off as given. The "AM Shift and PM Shift Pain Scale" on the MAR was not completed for 7/9/08.

On 7/09/08, the scheduled Oxycontin pain medication for 8:00 PM was administered at 4:45 PM. There was no documentation of Percocet given for breakthrough pain prior to the administration of the routinely scheduled 8:00 PM dose of OxyContin. There was no documentation of the resident's pain level prior to the early administration of the 8:00 PM dose of OxyContin.

2. Interview

On 7/9/08 at 5:00 PM, the Nursing Supervisor reported the resident "only received 2 doses of Cipro" before the antibiotic was changed due to a resident allergy.

Record Review

On 7/9/08 at 3:45 PM, the following documents were reviewed:

- The front page of the resident's chart was noted to have an orange allergy sticker in place that listed the following medications: "Levaquin, Ciprofloxin, Theodur."

- The resident's "Nursing Assessment/Full" form, dated 6/10/08 at 1820, listed the following medications as "Allergies: Theophylline, Levaquin, and Cipro Floxin."

- The resident's "Admission Orders Record" form, dated 6/10/08, listed the following medications as "Allergies: Theophylline,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295045 | A. BUILDING _____ B. WING _____ | C 07/09/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TORREY PINES CARE CENTER | 1701 S. TORREY PINES DRIVE LAS VEGAS, NV 89146 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 309 | Continued From page 5<br>Levaquin, Cipro, Floxin."<br><br>- The "Physician's Telephone Orders, dated 7/3/08, listed the following order, "T.O. (telephone order): "Cipro 500 mg per GT BID x (times) 10 days for UTI (urinary tract infection.)<br><br>- The "Physician's Telephone Orders, dated 7/5/08, listed the following order "Bactrim DS 500 mg 1 tablet per GT BID" and "D/C (discontinue) order of Cipro 500 mg Pt (patient) has allergic reaction to Cipro."<br><br>Resident #1 received 2 doses of the antibiotic Ciprofloxacin for a UTI despite an orange allergy sticker in place on the front of the resident's chart, and documentation of the drug allergy on the admission nursing assessment form and the admission orders record. | F 309 | | |